[redacted]

Mariners Hospital
BAPTIST HEALTH SOUTH FLORIDA

11/9/2018

Patient Name: [redacted] Parker, Jeannette M. [redacted]

Due Date: Upon Receipt

REQUEST FOR PAYMENT

Account Summary

Date of Service:	9/22/2018
Description of Service:	Emergency Department
Place of Service:	Mariners Hospital
Total Charges	$ 48,512.00
Insurance Payments / Adjustments	- $ 44,320.90
Prior Patient Payments	$ 0.00
AMOUNT YOU OWE	**$ 4,191.10**

Pay online! It's fast, easy, and secure.
https://billpay.baptisthealth.net

VISA MasterCard AMERICAN EXPRESS DISCOVER

[redacted]

Scan this code to pay with your smart phone.

Our automated system provides up-to-date information about your account 24/7 at 786-596-6507 or toll free at 1-800-235-0065.

See reverse side of this statement for frequently asked questions.

IMPORTANT MESSAGE

We previously notified you that the balance due is your responsibility. Our records indicate that we have not received payment for the account balance. We are requesting that you please pay the amount due immediately. If we do not receive your payment within 15 days we will consider your account past due. Pay online securely at: https://billpay.baptisthealth.net.

If you have any questions about your out-of-pocket expense, please contact your insurance provider so that they can explain how your claim was processed. Your insurance provider determines benefit coverage, and any patient financial responsibility. Our Baptist Health Customer Service Representatives do not have access to the terms of your insurance policy.

[redacted] Statement63

Mariners Hospital
BAPTIST HEALTH SOUTH FLORIDA
PO Box 830880
Miami, FL 33283

Pay By Mail for Account Number: [redacted]

Amount Due	Due Date	Amount Enclosed
$ 4,191.10	Upon Receipt	$ _____

[redacted]
Parker, Jeannette M.
[redacted]

Mail Payment Here

Mariners Hospital
PO Box 198116
Atlanta, GA 30384-8116

[redacted]

[redacted]

Baptist Health South Florida

Mariners Hospital
P O Box 198116
Atlanta, GA 303848116

Pt Name:	Jeannette M Parker	**ECD:**	[redacted]
Attending Physician:	[redacted]	**ENC:**	
Provider:	Mariners Hosp	**Statement Number:**	
Provider Tax ID #:	[redacted]	**Account Number:**	
Bill Date:	12/20/2018	**Claim ID:**	

Detail for: [redacted]

Date	Svc Cd	Description	Qty	Amount ($)
Charges				
09/22/2018	36603322	Immun admin ea add vacc toxinj	1	143.00
09/22/2018	49087547	Vacc boostrix 0.5 ml inj	1	112.00
09/22/2018	49003205	Augmentin 875mg tab	1	2.00
09/22/2018	36603314	Immun admin 1st vacc tox inj	1	143.00
09/22/2018	49011281	Vacc rabies 2.5u vial	1	968.00
09/22/2018	49033673	Imm glob rabies 2ml inj	6	46,422.00
09/22/2018	36600153	Level II	1	722.00
Payments/Adjustments				
10/19/2018		Cigna Insurance Payment		-34,618.50

The charges in this statement are a facility fee. A facility fee is intended to offset the operational and administrative costs of a facility and may include, without limitation, costs associated with nursing care, critical care, ancillary services, anesthesia, equipment, operating rooms, recovery rooms, supplies, medications, room and board, and other personnel and staff. Facility-based physicians and other health care providers who rendered services to the patient may bill separately. A list of such physicians and providers is available at http://BaptistHealth.net/AffiliatedPractices. Please contact the patient's insurer or HMO regarding any cost-sharing responsibilities.

Baptist Health South Florida
P O Box 830880
Miami FL 33283

ADDRESS SERVICE REQUESTED

JEANNETTE M. PARKER
[redacted]

Financial Coverages

Our record indicate the following insurance plans. Please call us as soon as possible with any changes or additions at (786) 596-6507 or 1 (800) 235-0065.

Priority	Plan Name	Policy #	Subscriber
1	Cigna Open Access Plus	[redacted]	[redacted]

Guarantor: Jeannette M. Parker

APWU HEALTH PLAN eHealthRecord PLUS

[redacted]

Claim Detail: Claim ID - [redacted]

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Patient

Name:	JEANNETTE PARKER
Address:	[redacted]
Member ID:	

Provider

Name (NPI):	MARINERS HOSPITAL (1518941806)
Address:	PO BOX 198193 ATLANTA, GA 30384
Network Indicator:	In Network

Claim Totals

Charges:	$48,512.00
Not Covered:	$9,680.00
Paid To:	MARINERS HOSPITAL
Check Number:	[redacted]
Plan Pays:	$34,618.50
Deductibles:	$344.60
Co-pay:	$0.00
Co-insurance:	$3,846.50
Other Insurance Paid:	$0.00
Member Resp.:	$4,191.10

$38,809.60 x 10% = $3880.96
Ded. 344.60
$4225.56?

Other

Service Date	REV Code	Charge	Allowed	Ins Paid	Not Covered	Member Resp.	Plan Paid	Reason Code
09/22/2018	0250	$2.00	$1.60	$0.00	$0.40	$1.60	$0.00	
09/22/2018	0450	$722.00	$577.60	$0.00	$144.40	$366.46	$211.14	
09/22/2018	0636	$968.00	$774.40	$0.00	$193.60	$77.44	$696.96	
09/22/2018	0636	$46,422.00	$37,137.60	$0.00	$9,284.40	$3,713.76	$33,423.84	
09/22/2018	0636	$112.00	$89.60	$0.00	$0.00	$8.96	$80.64	
Grand Total:		$48,512.00	$38,809.60	$0.00	$9,680.00	$4,191.10	$34,618.50	

[redacted]

Service Date	REV Code	Charge	Allowed	Other Ins Paid	Not Covered	Member Resp.	Plan Paid	Reason Code
09/22/2018	0771	$143.00	$114.40	$0.00	$28.60	$11.44	$102.96	
09/22/2018	0771	$143.00	$114.40	$0.00	$28.60	$11.44	$102.96	
Grand Total:		$48,512.00	$38,809.60	$0.00	$9,680.00	$4,191.10	$34,618.50	

Back to claim search

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